# FORM 2 - GENERIC HEALTH CARE MANAGEMENT & EMERGENCY RESPONSE PLAN

**Name:** **DOB:** **Year:** **Form:** **Teacher:**

**Section A – Health Care Planning – to be completed by the parent/carer**

Name of your child's health condition or need:

Daily Management Planning (if required):

**Section B – Emergency Response Plan (if required) – To be completed by parent/carer and or medical practitioner**

**Section C – Staff Training Requirements**

Is specific training for staff required to manage your child's condition or needs? (You may like to discuss with the principal or a medical practitioner).

A. For daily management? Yes ☐ No ☐ If yes, please describe:

B. In an emergency? Yes ☐ No ☐ if yes, please describe:

**Section D – Medication Instructions** (Note: Medication must be provided by parents/carers)

| | Medication 1 | | Medication 2 | | Medication 3 | |
|---|---|---|---|---|---|---|
| Name of medication | | | | | | |
| Expiry date | | | | | | |
| Dose/frequency – (may be as per the pharmacist's label) | | | | | | |
| Duration (dates) | From:<br>To: | | From:<br>To: | | From:<br>To: | |
| Route of administration | | | | | | |
| Administration<br>Tick appropriate box | By self<br>Requires assistance | ☐<br>☐ | By self<br>Requires assistance | ☐<br>☐ | By self<br>Requires assistance | ☐<br>☐ |
| Storage instructions<br>Tick appropriate box(es) | Stored at school<br>Kept and managed by self<br>Refrigerate<br>Keep out of sunlight<br>Other | ☐<br>☐<br>☐<br>☐<br>☐ | Stored at school<br>Kept and managed by self<br>Refrigerate<br>Keep out of sunlight<br>Other | ☐<br>☐<br>☐<br>☐<br>☐ | Stored at school<br>Kept and managed by self<br>Refrigerate<br>Keep out of sunlight<br>Other | ☐<br>☐<br>☐<br>☐<br>☐ |

| Name: | DOB: | Year: | Form: | Teacher: |
|---|---|---|---|---|

**Section E –Authority to Act.**

I/we authorise school staff to provide health care support for my/our child in accordance with the above plan and/or the attached plan from a medical practitioner. It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.

| Parent/Carer:<br><br>Date: | Medical Practitioner: If required (At the principal's discretion)<br><br>Date: |
|---|---|
| Review Date: | |

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| Date received: / / | Date uploaded on SIS: / / |
|---|---|
| Is specific staff training required? **Yes** ☐ **No** ☐: | Type of training: |
| Training service provider: | |
| Name of person/s to be trained:<br><br>Date of training: | |

**When completed, please attach to the *Student Health Care Summary* form.**